CALIFORNIA DEPARTMENT OF
Mental Health

# LTCS BEST PRACTICE CATALOG SUBMISSION COVER SHEET

**TYPE OF SUBMISSION:**

☐ **NEW**

☒ **REVISED - Replaces** I. C. 1 015
**Current submission catalog number**

☐ **UPDATE - To** _____
**Current submission catalog number**

☐ **CHANGE IN CONTACT INFORMATION**


**Name:** Peggy Phaklides, RN

**Telephone Number:** 805-468-3396

**E-Mail Address:** Pphaklides@dmhash.state.ca.us


**Date Submitted To Hospital/Division:** _____

**Approved for submission to LTCS Best Practice Committee** ☐

**Date Submitted To LTCS Best Practice Committee:** _____

**Approved for submission to LTCS Best Practice Catalog** ☐

California Department of Mental Health

# LTCS BEST PRACTICE CATALOG SUBMISSION

**Project Title: Restraint Flow Chart – (R / S Documentation Sheet) REVISED**

**Function Category:**

☒ **PATIENT-FOCUSED** ☐ **ORGANIZATION** ☐ **STRUCTURES**

**Sub-category(s): Care of Patient** **Heading: Behavior Management**

**Contact Person: Peggy Phaklides, RN** **Telephone Number: 805-468-3396**
**E-Mail Address:** Pphaklides@dmhash.state.ca.us

**Hospital:** **Atascadero State Hospital**

**The following items are available regarding this Best Practice:**

☒ **Sample Flow Sheet**

☐ **Photographs** ☐ **Video Tape** ☐ **Drawings** ☐ **Manual**

1. **SELECTION OF PROJECT/PROCESS AREA (Describe how and why your team selected this project/process area for improvement.):**

   The State and Federal laws and regulations, as well as the JCAHO standards, governing the application and use of any form of restraint or seclusion have inherently stringent guidelines. Documentation surrounding the use of restraint or seclusion must then contain all the required elements to justify its use and ensure that the patient's rights have not been violated.

**The new revised version of this form includes 2 changes that further improve the form's usefulness**

1. **A title change on the form including check boxes so the form can either be used or Restraint and Seclusion OR be used to chart 15 minute observations on patients who need very similar documentation but are not in restraint or seclusion.**

**I. C. 1. 015**

2. **Documentation elements required from the new JCAHO Pain Management assessment standards.**

2. **UNDERSTANDING EXISTING CONDITION WHICH NEEDS IMPROVEMENT**
**(Describe the relationship of your project to your goals for improvement, and describe current process performance.):**

The Level of Care staff when documenting the patient's physical and mental condition, level of restraint used, nursing care given, fluid intake/output, documentation of the patient's behaviors every fifteen minutes, and summary documentation every two hours required the use of several forms located in different sections of the medical record. Due to the logistics of forms/documents within the chart, omission or incomplete documentation is possible. The absence of any of this vital information places the staff and hospital in a vulnerable position.

3. **ANALYSIS** **(Describe how the problem was analyzed.):**

Ongoing chart audits by numerous departments, as well as the Patients' Rights Advocate revealed less than perfect documentation surrounding the use of restraint or seclusion. A consolidated method to document the nursing care provided and the patient's progress was deemed necessary to obtain a complete, current and ongoing picture of the patient's status.

4. **IMPLEMENTATION** **(Describe your implementation of the solution.):**

A team of staff met to review all required elements R & S documentation, establish weak points and redundancies of chartings, and develop at tool, the "Restraint Flow Sheet", to solve the problem. The form is printed on 1-side, on an easily recognizable colored card stock page and is filed chronologically in the ID notes of the patient's chart.

5. **RESULTS** **(Demonstrate that an improvement has occurred as a result of the project/process area implementation.):**

The tool provides a 24hour tracking sheet which prompts the nursing staff to review and address the essential elements required in the documentation of a patient's status while in restraint or seclusion. Vital elements include 1) nursing care provided, e.g., ROM, I & O, vital signs, skin condition assessments , environmental conditions, etc.; 2) review of alerts for risk factors in the use of restraint or seclusion; 3) triggers for referral for consults if the patient is in R&/or S for greater than 72-144-216 hours; 4) denial of rights considerations; and 5) every 15 minutes observations of the patient's behaviors, **and now, Pain Management Assessment.** With the consolidation of numerous forms into one tool, in one location, the level of care staff are able to focus the written documentation in the

interdisciplinary notes to delineate the patient factors, (mental and behavioral) which justify the continued use of R&S.

6. **LEARNING** **(Describe what the team learned and how they used those lessons to continuously improve the success of this Best Practice.):**

The team found that incorporation of numerous requirements from several different sources, into an existing and already complicated system is fraught with numerous problems. Input solicited from all levels of the organization can help with buy-in and facilitate the process to a desirable outcome. The team also discovered that once the change and acceptance to the new documentation system was completed, the level of care staff found more time was available for direct patient care, less time was spent on the documentation, and compliance with the regulatory requirements was improved.